STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	555140	A. Building B. Wing	03/13/2025

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
Bradley Court	675 E Bradley El Cajon, CA 92021

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure medication error rates are not 5 percent or greater. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 47466 Based on observation, interview and record review, the Facility failed to ensure the facility was free of medication errors less than 5% or higher. The facility's medication error rate was 7.69 %. Two (2) medication errors were observed, a total of 28 opportunities, during the medication administration process for two (2) of 4 randomly observed residents (Residents 5, 52). As a result, the Facility could not ensure medications were correctly administered to all residents. Findings: 1) Resident 52 was admitted to the facility on [DATE] with diagnoses that included diabetes mellitus (abnormal blood sugar) and schizoaffective disorder (a mental illness that can affect thoughts and mood) per the Admission Record. On [DATE] at 7:30 A.M., an observation during medication administration was conducted with licensed nurse (LN) 6. LN 6 administered vitamin C 500 mg to Resident 52 from a bottle that read vitamin C 500 mg, dated opened on [DATE] and expired on [DATE]. A joint interview and record review on ,d+[DATE]/ 25 at 9:15 A.M., was conducted with LN 6. LN 6 stated that the medication administration record (MAR) indicated, vitamin C oral 1 tablet (Ascorbic acid). Give 1 tablet by mouth one time a day for supplement. LN 6 stated there was no dose indicated on the MAR for the vitamin C that LN 6 gave to Resident 52. LN 6 stated he should have verified the dose prior to administering the medication. LN 6 stated it was important to give the right dose for Resident 52 to prevent possible decline in Resident 52's health and to ensure doctor's orders were followed. An interview with the Director of Nursing (DON) on [DATE] at 9:12 A.M., was conducted. The DON stated every medication should have a dose which was important for Resident 52's health condition. The DON stated it was important to follow the 7 rights of medications administration- right patient, right drug, right dose, right time, right route, right reason and right documentation . 2) Resident 5 was admitted to the facility on [DATE] with diagnoses that included Vitamin D (used to maintain healthy bones and teeth) deficiency and obesity (a disorder that involves having too much body fat) per the Admission Record. (continued on next page)

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE

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F 0759 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	On [DATE] at 8:00 A.M., an observation during medication administration was conducted with LN 6. LN 6 administered vitamin D,d+[DATE] mcg/2000 units to Resident 5 from a bottle that read vitamin D3 50 mcg/2000 IU which was opened on [DATE] and expired on [DATE]. A joint interview and record review on ,d+[DATE]/ 25 at 9:15 A.M., was conducted with LN 6. LN 6 stated the medication administration record (MAR) indicated, vitamin D3 50 mcg/ 2000 UT (cholecalciferol) Give 1 capsule by mouth in the morning for vitamin D deficiency. LN 6 stated he assumed UT was the same measurement as unit. A phone interview on [DATE] at 3:08 P.M., with the facility's contracted pharmacist (PH) was conducted. The PH stated vitamin D3 was always dosed in International Units, and was never dosed in UT. The PH stated UT was not a unit of measurement for any medication. An interview on [DATE] at 9:20 A.M., with the DON was conducted. The DON indicated that it was important to administer the correct dose of all medications to prevent any side effects. A review of the facility's policy titled Medication Administration dated [DATE] indicated, . #4. medications are administered in accordance with the prescriber orders, including required time frame . #10. the individual administering the medication checks the label three (3) times to verify the right resident, right medication, right dosage .before giving medication.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0761 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Few	Ensure drugs and biologicals used in the facility are labeled in accordance with currently accepted professional principles; and all drugs and biologicals must be stored in locked compartments, separately locked, compartments for controlled drugs. 47466 Based on observation, interview and record review, the facility failed to ensure a medication storage room was free of staff's food and personal belongings. This failure had the potential for lack of oversight and contamination for medications stored in the facility. Findings: On 3/12/25 at 11:02 A.M., a joint observation and interview was conducted with licensed nurse (LN) 6. in the medication storage room. The medication storage room was observed with staff's personal belonging including two large purses. In addition, a box of donuts, a large carafe of coffee was observed on the counter. LN 6 stated the purses and food items belonged to staff, and did not belong to any residents in the facility. LN 6 stated personal belongings should not be stored in a medication storage room which stores medications including controlled drugs (medications which have a potential for abuse and addiction). On 3/13/25 at 9:12 A.M., an interview was conducted with the Director of Nursing (DON). The DON stated personal belongings should never be stored in the medication storage area to prevent drug diversion. The DON stated food items should never be stored in the medicaiton storage room to prevent pest infestation. A review of the facility's undated policy titled, medication labeling, and storage indicated .#2. the nursing staff is responsible for maintaining medication storage and preparation areas in a clean, safe and sanitary manner. #6.medications are stored separately from food and are labeled accordingly.

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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	Procure food from sources approved or considered satisfactory and store, prepare, distribute and serve food in accordance with professional standards. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation, interview and record review, the facility failed to ensure proper food storage and sanitation practices were met in the kitchen according to standards of practice when: 1. A cut up onion was undated, covered in a clear plastic wrap, and stored in a bin with uncut onions. 2. Whipped topping 11 days past the use-by date was stored in the refrigerator. 3. A floor sink had piping without an air gap (space) of at least 1 (inch) between the pipe and drain. These failures exposed residents to contaminated food and unsanitary practices, which had the potential to place them at risk of developing foodborne illness. Findings: 1. During the initial kitchen tour on [DATE] at 7:50 A.M., an observation and interview with the Food Service Director (FSD) was conducted. A plastic bin filled with fresh onions were observed on a storage shelf at the food preparation area. The plastic bin was labeled with a Received Date of [DATE], and a Use By date of [DATE]. An onion that had been peeled and cut into was observed inside the bin, atop the fresh onions. The peeled/cut onion was wrapped in clear plastic wrap, and did not have a label or date on it. The FSD stated, I think the cook used [the peeled/cut onion] this morning for breakfast . On [DATE] at 7:53 A.M., an interview was conducted with [NAME] 1. [NAME] 1 stated he cooked breakfast for the facility this morning, but did not use any onions. [NAME] 1 stated he did not know when the onion was cut, or how long it had been in the plastic bin, and it should have been labeled with a date. A review of the facility's policy titled Labeling and Dating of Foods, dated 2023 indicated, POLICY: All food items in the storeroom, refrigerator, and freezer need to be labeled and dated . 2. During the initial kitchen tour conducted on [DATE] 8:02 A.M., a plastic bag with a white substance was observed on the top shelf in Refrigerator 2. The plastic bag was labeled, Whipped Topping. There was a sticker label placed on the plastic bag which indicated, Use-by date [DATE]. The FSD stated the whipped topping should have been discarded on [DATE]. The FSD stated, .we need to make sure we don't use it if it expired. It can cause diarrhea . A review of the facility's policy titled Storage of Food and Supplies dated 2023 indicated, POLICY: Food and supplies will be stored properly and in a safe manner. (continued on next page)

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F 0812 Level of Harm - Minimal harm or potential for actual harm Residents Affected - Some	3. During the initial kitchen tour conducted on [DATE] at 9:40 A.M., a floor sink drain underneath the dish washing machine was observed with two PVC (polyvinyl chloride) black pipes and one metal pipe extending into the floor drain. The FDS acknowledged the three pipes going into the floor sinks. According to the 2022 Federal FDA Food Code, section ,d+[DATE].11(A), .A direct connection may not exist between the sewage system and a drain originating from equipment in which food, portable equipment .are placed .

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F 0911 Level of Harm - Potential for minimal harm Residents Affected - Some	Ensure resident rooms hold no more than 4 residents; for new construction after November 28, 2016, rooms hold no more than 2 residents. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Based on observation and review of the Analysis of Accommodations (document with measurements of the square footage of the useable living space of individual resident rooms and approved capacities), the facility failed to ensure that 1 of 10 resident rooms (room [ROOM NUMBER]) in Building 2 accommodated 4 or less residents. Findings: During the initial tour of Building 2 on 3/10/25, room [ROOM NUMBER] was observed to have 6 resident beds in the room. During a review of the facility's Analysis of Accommodations on 3/13/25, the document indicated room [ROOM NUMBER] had 6 residents housed in the room. There were no quality of care or quality of life issues identified during the survey for the six residents that resided in room [ROOM NUMBER]. A contuinance of a waiver allowing the six-bed room was therefore recommended.

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F 0912 Level of Harm - Potential for minimal harm Residents Affected - Some	Provide rooms that are at least 80 square feet per resident in multiple rooms and 100 square feet for single resident rooms. **NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 49330 Bedrooms must measure at least 80 square feet per resident in multiple resident bedrooms, and at least 100 square feet in single resident rooms. Based on observation and record review, the facility did not meet the minimum requirement of 80 square feet per resident in Building 1 (rooms 2, 3, 4, and 5) and in Building 2 (rooms [ROOM NUMBERS]). Findings: A review of the facility's Analysis of Accommodations indicated there were 6 of 24 resident rooms that did not meet the minimum room size requirement, as follows: 1. Building 1, room [ROOM NUMBER] with 2 resident occupancy, 75 sq. ft. per resident, totaling 150 sq. ft. 2. Building 1, room [ROOM NUMBER] with 2 resident occupancy, 75 sq. ft. per resident, totaling 150 sq. ft. 3. Building 1, room [ROOM NUMBER] with 2 resident occupancy, 75 sq. ft. per resident, totaling 150 sq. ft. 4. Building 1, room [ROOM NUMBER] with 2 resident occupancy, 75 sq. ft. per resident, totaling 150 sq. ft. 5. Building 2, room [ROOM NUMBER] with 4 resident occupancy, 64.5 sq. ft. per resident, totaling 258 sq. ft. 6. Building 2, room [ROOM NUMBER] with 4 resident occupancy, 66.75 sq. ft. per resident, totaling 267 sq. ft. The variations in room size requirements did not adversely affect the resident's health, safety, quality of care, or quality of life during the survey. A continuance of the room size waiver for all affected rooms were recommended.